The Tulalip Tribes
Dependent Care Reimbursement Claim Form

Employee Name: _____ Date: _____

Dependent Name(s): _____

_____

_____

_____

Day Care Provider: _____ SS# _____-_____-_____

Address: _____

_____

_____

Dates of Service: _____ through _____

Charges for Services: _____ Per hr. _____ Per Day _____ Per Week _____

Total Charges: _____

_____
(Day Care Provider Signature)

Employee Certification

I hereby certify that all items requested to be reimbursed comply with the The Tulalip Tribes Flexible Spending Account and such items have not and will not be covered by any other plan or program of any employer or other person. I further certify that such items will not be deducted or taken as tax credits on my personal federal and state income tax returns for any year. The Company does not accept responsibility for direct payment to any individuals other than the employees.

Employee Signature: _____ Date: _____

Submit this form (retain a copy for your records) by mail or fax to:

CBSolutions LLC Fax: 425-391-9715
ATTN: Flex Plan Administrator
160 NW Gilman Blvd. Ste. 3
Issaquah, WA 98027

NOTICE:

All employees participating in a Section 129 Dependent Care Flexible Benefit Plan are required to file Form 2441 with the IRS by April 15 of the year following your participation in this plan.